# APPLICATION FOR LICENSE AS AN ASSOCIATE MARRIAGE & FAMILY THERAPISTS


## GEORGIA STATE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND MARRIAGE & FAMILY THERAPISTS

**Post Office Box 13446**
**Macon, Georgia 31208**
**Phone (478) 207-2440**
**www.sos.state.ga.us/plb/counselors**


Please read the instructions carefully and be familiar with the laws and rules governing the practice of Marriage & Family Therapy in the State of Georgia. Visit the following web site for information: http://www.sos.state.ga.us/plb/counselors.

****Important****

**The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all information and documentation is complete and correct. Incomplete applications result in delayed processing. Incomplete applications are void after one year.**

## Application Checklist

**The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.**

The **non-refundable application fee** made payable to Georgia Professional Counselors, Social Workers, and Marriage & Family Therapists must be included with the application. (please see Fee Schedule at the Board's website)

**PLEASE ACCESS THE BOARD RULES WHICH INCLUDES LICENSURE REQUIREMENTS FROM OUR WEBSITE AT WWW.SOS.STATE.GA.US/PLB/COUNSELORS**

# Application Checklist

- ❑ **NOTARIZED APPLICATION:** The five-page application must be mailed to the Board's office at the address listed above, along with your **FEE**. All questions must be answered. Any question answered "yes", requires further documentation to be submitted. Request official court documents be submitted to the Board and provide an explanation if you have had any criminal convictions or charges, or sanctions by another state licensing board. The Board will review a complete application with all required documentation at their next scheduled meeting. Approval of licensure is at the Board's discretion.

- ❑ **NATIONAL BOARD SCORES:** If you have not taken the MFT exam thru PES, you will receive the exam packet information after Board approval. All applicants are required to pass the Marriage & Family Therapy Examination/PES exam. If you have taken the MFT exam, please contact the National Board Administrative Offices at (212) 367-4389 and have them certify your scores to Georgia.

- ❑ **DEGREE TRANSCRIPT:** All applicants for licensure must have earned a master's degree in marriage & family therapy, counseling, social work, medicine, applied psychology, psychiatric nursing, pastoral counseling, applied child and family development, applied sociology, or from any program accredited by the Commission on Accreditation for Marriage and Family Therapy Education. Such degree shall be from an educational institution accredited by a regional body recognized by the Council on Post Secondary Accreditation. An **OFFICIAL** college transcript certifying the grades, degree conferred and the date awarded must be received in this office directly from the Registrar of the college/school.

- ❑ **FORM A/INTERNSHIP VERIFICATION:** The instructor of record at the college or university or the Site Supervisor may be verified by the school as part of the master's degree program which includes a graduate level course over 12 consecutive months, under supervision, minimum of 500 hours MFT clinical contact.

- ❑ **FORM B/PRACTICUM/INTERNSHIP VERIFICATION:** Practicum/Internship must meet minimum requirements set out in Board Rule 135-5-.06(a)(21-24). Complete a separate form for each Practicum/Internship listed on your application.

- ❑ **CONTRACT AFFIDAVIT:** You must complete and submit all 4 pages of this form in its entirety. The purpose of the contract affidavit is to define the employment relationship for the purpose of acquiring the required postmaster's experience under supervision that will be applicable for licensure. Independent private practice is not acceptable as "employment" for the purposes of obtaining directed experience under supervision.

- ❑ **OTHER STATE LICENSURE CERTIFICATION:** If you are or have ever been licensed in another State(s), please have that/those State(s) officially certify that license directly to the Board's office.

- ❑ **REFERENCES:** Please submit references from two (2) teachers or supervisors who are familiar with their experience in Professional Counseling.

- ❑ **CONSENT FORM:** Please sign the consent form giving permission for the Board to receive any criminal history record information.

- ❑ If your name has changed since you attended school, please make a note on the application advising of your former name(s) so we can match-up the documents with your application.

- ❑ **IMPORTANT:** Applicants, please note when accessing your application status on our website under the *Online Services* category *Check the Status of an Application* that checklist items that have been moved over to the completed column only means that those documents have been received. This tool is to be used as an option for you to monitor your application for items received as you are going through the licensure process.

  Only the Georgia Composite Board of Professional Counselors, Social Workers and Marriage & Family Therapists has the authority to approve or deny an application for licensure. Every application file must be submitted to the Board for review. The Board meets monthly to review applications and conduct other Board business. Once your application file has been reviewed by the Board, you will receive written communication of the Board's decision within five to seven working days after the Board meeting.

| FOR BOARD USE ONLY | |
|---|---|
| Amount Submitted | _____ |
| Date | _____ |
| Receipt # | _____ |

| FOR BOARD USE ONLY | |
|---|---|
| Certificate Number | _____ |
| Date Issued | _____ |
| Applicant No. | _____ |

# GEORGIA STATE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE & FAMILY THERAPISTS

Post Office Box 13446 • Macon, Georgia 31208 • (478) 207-2440
www.sos.state.ga.us/plb/counselors

## APPLICATION FOR LICENSE AS AN

## ASSOCIATE MARRIAGE & FAMILY THERAPIST

**Application Fee $100 (non-refundable)**

**Additional License Types (currently or previously issued by the Georgia Professional Licensing Boards):** _____

**Method Obtained by:**
Applicant is applying for above referenced license by:
( ) Examination
( ) Examination Waiver (only if you have already taken the MFT exam thru PES)

**Name** _____
First Middle Last

Name as shown on exam records or transcripts
(if different) _____
First Middle Last

_____ _____
***Social Security Number** **Date of Birth**

* This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A. 1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

**Physical Address** _____
Number and Street Apt. No City/State Zip

***P.O. Box not acceptable – Please note that your physical address will be made public as part of your licensure verification.***

**Mailing Address** _____
(if different) Number and Street Apt. No City/State Zip

_____ _____
Telephone Number Day Telephone Number Evening

_____ I am a U.S. citizen.

_____ I am not a U.S. citizen, but am a qualified alien under the federal Immigration and Naturalization Act, and I am lawfully present in the United States.

Email Address: _____

## PART II - PROFESSIONAL BACKGROUND

PROFESSIONAL BACKGROUND: ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS. IF "YES," TO 1 THROUGH 9, ATTACH A DETAILED EXPLANATION.

❒ Yes ❒ No 1. Are you unable to practice safely as a result of use of alcohol or other drugs?

❒ Yes ❒ No 2. Have you been denied professional licensure or renewal because of a license disciplinary proceeding?

❒ Yes ❒ No 3. Have you ever had a license to practice social work, counseling, marriage and family therapy, or any other profession revoked, suspended or annulled or otherwise sanctioned, including by private order, by any board or agency in Georgia or any other state, territory, or country?

❒ Yes ❒ No 4. Have you been subject to disciplinary action or had your membership revoked by any professional organization?

❒ Yes ❒ No 5. Have you knowingly failed to renew a license during an investigation of a disciplinary matter against you?

❒ Yes ❒ No 6. To the best of your knowledge, is there any disciplinary action or investigation pending against you by any licensing board, agency, or professional organization?

❒ Yes ❒ No 7. Have you ever been convicted of any criminal offense?

❒ Yes ❒ No 8. Have you ever been arrested, charged, or sentenced for the commission of a felony, misdemeanor (other than minor traffic or parking violations) or any crime of moral turpitude, including the entry of a plea of nolo contender or a plea entered pursuant to the provisions of the "Georgia First Offenders Act"? You must respond "yes" if you plead and completed probation as a First Offender. If yes, provide certified copies of the court disposition.

❒ Yes ❒ No 9. Have you been the defendant in a malpractice suit and either entered into a settlement agreement or paid court awarded expenses?

❒ Yes ❒ No 10. Do you now hold or have you ever held a license as a social worker, professional counselor, or marriage and family therapists in any jurisdiction? If "yes," complete the following:
Jurisdiction _____ License No._____
Date Issued_____ Expiration _____

❒ Yes ❒ No 11. Have you previously applied to the Board for the same license for which you are currently applying?
If "yes," name under which application was submitted: _____

❒ Yes ❒ No 12. Have you ever served on active duty in the Armed Forces, the Reserves or the National Guard during wartime or during any conflict when military personnel were committed by the President? If "Yes," you may be eligible for Veterans' Preference Points to be added to your examination score. Submit your DD214 Form to the Board office.

## PART III — GRADUATE EDUCATION

INSTRUCTIONS:

- For licensure as an Associate Marriage and Family Therapists, you must have satisfied one of three (3) educational requirements. See Board Rule Chapter 135-5-.05(b).
- Direct the Registrar of your institution(s) to send an official copy of your transcript directly to the Board office.

## A - EDUCATIONAL REQUIREMENTS

CHECK THE APPLICABLE EDUCATIONAL REQUIREMENTS YOU MEET:

❒ 1. I earned a master's degree from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). The program, at the time the degree was awarded, was fully approved by COAMFTE. Date Degree Received: _____
Name of School: _____
Date degree program was fully approved by COAMFTE:_____
❒ Letter of Verification attached.

❒ 2. I earned a master's degree from a program in Marriage and Family Therapy, as specified in Board rules, from a recognized educational institution and will COMPLETE PART III - C.

❒ 3. I completed a program, including an earned master's degree and additional post-master's coursework, as specified in Board Rules. All coursework, including the master's degree and all post-graduate coursework, was earned from a recognized educational institution and will COMPLETE PART III - C.

## B - MASTER'S DEGREE

Official Title of Program [As Listed on Transcript]:

Date Awarded:

Name of Institution:

Address: _____
Street City State Zip

## C - MFT COURSEWORK

■ **If you meet the educational requirements listed in Number 2 or 3 above, complete this section.**
■ Complete Form A - Practicum/Internship Verification and Forms B or C — Practicum/Internship Supervision Verification.
■ **Under Number 2** — To qualify for licensure, at a minimum your master's degree program must have included all of the following courses. See Board Rule 135-5-.05(a)(4).
■ **Under Number 3** — You must have an earned master's degree and have completed additional post-graduate coursework in marriage and family therapy. Such coursework must have included, at a minimum, ALL of the following courses. See Board Rule 135-5-.05(a)(5).

| **Course Title and Number** | **Institution** |
|---|---|
| THREE (3) COURSES IN MARRIAGE AND FAMILY STUDIES | |
| A "Marriage and Family Studies Course" includes the study of the theory and practice of the principles, concepts, or history of marriage and family life, family systems, family relations and family development. Board Rule 135-5-.05(a)(6). | |
| 1. | |
| 2. | |
| 3. | |
| THREE (3) GRADUATE LEVEL COURSES IN MARRIAGE AND FAMILY THERAPY | |
| A "Marriage and Family Therapy Course" includes the study of the theory and practice of various treatment modalities in marriage and family therapy. Board Rule 135-5-.05(a)(7). | |
| 1. | |
| 2. | |
| 3. | |

| THREE (3) COURSES IN HUMAN DEVELOPMENT | |
|---|---|
| "Human development courses" encompass the study of all aspects of individual development across the life span. Such courses include, but are not limited to, theories of individual development, theories of learning, theories of personality development, theories of normal and abnormal behavior, human sexuality, and psychopathology. Board Rule 135-5-.05(a)(8). | |
| 1. | |
| 2. | |
| 3. | |

| ONE (1) COURSE IN MARRIAGE AND FAMILY THERAPY ETHICS | |
|---|---|
| A course in "Marriage and Family Ethics" includes, but is not limited to: state and federal laws, Rules of the Georgia Composite Board of PC, SW & MFT, professional ethics, legal responsibilities and liabilities, professional socialization, professional organization, interprofessional cooperation, licensure legislation and independent practice. Board Rule 135-5-.05(a)(9). | |
| 1. | |

| ONE (1) COURSE IN RESEARCH | |
|---|---|
| A course in "Research" includes, but is not limited to, research design, methods, and statistics, but not credit received for thesis or dissertation. Board Rule 135-5-.05(a)(10). | |
| 1. | |

| A ONE-YEAR PRACTICUM/INTERNSHIP UNDER SUPERVISION IN MARRIAGE AND FAMILY THERAPY | | | |
|---|---|---|---|
| 1. | | | |
| Date Began: | Date Ended: | Total # Hours Clinical Experience: | Total # Hours of Supervision: |
| NAME OF SUPERVISOR: | | MFT License # | State: |

❒ Board-Approved Supervisor ❒ AAMFT-Approved Supervisor or Supervisor in Training ❒ Not an Approved Supervisor

## PART V - POST-MASTER'S DIRECTED EXPERIENCE UNDER SUPERVISION

INSTRUCTIONS:

- An applicant for licensure as an Associate Marriage and Family Therapist must submit to the Board the Post-Master's Experience Under Direction and Supervision Contract Affidavit.
- This Contract Affidavit must be approved by the Board prior to beginning any post-master's experience.
- However, **if the written examination is taken and passed at the first regularly-scheduled date after completion of all educational requirements**, experience under direction and supervision accrued from the date of completion of all educational requirements until approval of the Contract Affidavit by the Board may be included as part of the required post-master's experience.
- **If the applicant does not take and pass the first regularly-scheduled examination**, the accrual of the required post-master's experience under direction and supervision shall begin only after successful completion of the examination and the Board's approval of the Contract Affidavit.

DATE ALL EDUCATIONAL REQUIREMENTS WERE COMPLETED:

DATE MFT EXAMINATION TAKEN AND PASSED (IF APPLICABLE):

❒ I have completed and am submitting as part of this application the Post-Master's Directed Experience Under Supervision Contract Affidavit.

❒ I acknowledge that if I change work settings, contract terms, or supervisors, I must request and receive approval from the Board by completing a new Contract and submitting it to the Board for approval.

## PART VI - OATH

I, THE UNDERSIGNED APPLICANT, DO HEREBY AFFIRM UNDER PENALTY OF PERJURY THAT ALL STATEMENTS MADE AND INFORMATION CONTAINED IN THIS APPLICATION ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. FURTHER, I CONSENT TO A THOROUGH INVESTIGATION OF MY EDUCATIONAL RECORDS AND OTHER INFORMATION THAT MAY BE NECESSARY TO VERIFY MY QUALIFICATIONS FOR PRACTICE AS A LICENSED ASSOCIATE MARRIAGE AND FAMILY THERAPIST. I ACKNOWLEDGE THAT I MAY BE REQUIRED TO FURNISH ADDITIONAL INFORMATION PROMPTLY IN ORDER FOR THIS APPLICATION TO BE PROCESSED. I UNDERSTAND THAT IF THE BOARD EVER TAKES PUBLIC DISCIPLINARY ACTION AGAINST ME, THE BOARD WILL REPORT THAT ACTION, WITH MY SOCIAL SECURITY NUMBER, TO THE APPROPRIATE DISCIPLINARY TRACKING SYSTEMS.

_____ _____

Date Signature of Applicant

Sworn and subscribed to before me this
____ day of _____, _____.

_____

Notary Public

My Commission Expires: _____ NOTARY SEAL

GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS, AND
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237 Coliseum Drive, Macon, Georgia 31217-3858
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www.sos.state.ga.us/plb/counselors

# MARRIAGE AND FAMILY THERAPY PRACTICUM/INTERNSHIP VERIFICATION FORM A

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly. For additional forms, please photocopy. This is a 2-sided form.
- Practicum/Internship must meet the requirements set out in Board Rule 135-5-.06(a)(21-24) [Graduate level course over 9 - 12 consecutive months, under supervision, minimum 500 hours MFT clinical contact.]
- **Applicant** – Complete Part I.
- **On-Site Coordinator of Practicum/Internship** - Complete Part II.

## PART I - TO BE COMPLETED BY APPLICANT

Name:

Address: _____
Street City State Zip

√ Check applicable and complete information below:

❒ Practicum/Internship which was **part of my degree program** OR

❒ Practicum/Internship **before or after the master's degree**.

√ Check Type of Practicum/Internship: ❒ MFT ❒PC ❒SW

Institution: Degree:

Course Title & Number: Supervisor:

Practicum/Internship Site:

Address:

Position/Title:

Description of Responsibilities:

| DATES: | FROM: Month/Year | TO: Month/Year |
|---|---|---|
| DURATION: | TOTAL YEARS: | TOTAL MONTHS: |

## HOURS OF ON-SITE EXPERIENCE

| Individuals: | Group: | Couples/Families: |
|---|---|---|

## OATH

I attest that the above information is a true and accurate representation of my Practicum/Internship.

_____ _____
Date Signature of Applicant

Subscribed to and sworn before me_____
this ____day of _____,_____ Printed Name

_____
Notary Public
My Commission Expires: _____ NOTARY SEAL

## PART II - TO BE COMPLETED BY THE ON-SITE COORDINATOR

INSTRUCTIONS:

- Please review the applicant's description of his/her Practicum/Internship experience. If you have any additional information that would assist the Board in making a decision on licensure for this applicant, please provide that information below.
- Complete A or B below, as applicable.

ADDITIONAL INFORMATION:

## A - ACTUAL ON-SITE COORDINATOR

ATTESTATION:

**I attest that I served as the On-Site Coordinator for the Practicum/Internship described above and that this description is a true and accurate representation of this applicant's experience.**

_____ _____

Date Signature of On-Site Coordinator

_____

Printed Name

Name of Site:

Address: _____

Street City State Zip

Work Phone: ( ) Home Phone: ( ) Fax: ( )

## B - CURRENT ON-SITE COORDINATOR

ATTESTATION:

**I attest that the person who coordinated this applicant's Practicum/Internship cannot be located and that I am the current On-Site Coordinator and can verify this applicant's experience based upon a review of the available records. After a diligent and thorough search of available records, I attest that the Practicum/Internship described above is a true and accurate representation of this applicant's experience.**

_____ _____

Date Signature of Current On-Site Coordinator

_____

Printed Name

Name of Site:

Address: _____

Street City State Zip

Work Phone: ( ) Home Phone: ( ) Fax: ( )

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# MARRIAGE AND FAMILY THERAPY
# PRACTICUM/INTERNSHIP SUPERVISION VERIFICATION
# FORM B

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print clearly.
- Practicum/Internship must meet minimum requirements set out in Board Rule 135-5-.06(a)(21-24).
- **Applicant** – Complete Part I. For additional forms, please photocopy. Complete a separate form for each Practicum/Internship listed on you're application.
- **Practicum/Internship Supervisor** - Complete Part II. After you have completed this form and it has been notarized, enclose it in a sealed envelope, sign your name over the flap and return it to the applicant.

## PART I - TO BE COMPLETED BY APPLICANT

Name: Social Security #:

## PART II - TO BE COMPLETED BY THE PRACTICUM/INTERNSHIP SUPERVISOR

Name of Supervisor:

Type of License: ❒MFT ❒LPC ❒CSW ❒PSYCHOLOGIST ❒ PSYCHIATRIST

License # State: Date Issued: Expiration Date:

CERTIFICATION:

I hereby certify that I supervised the Internship/Practicum of the above-named applicant who practiced:

❒ Marriage and Family Therapy ❒ Professional Counseling ❒ Social Work

Practicum/Internship Site:

Address: _____
Street City State Zip

| FROM: Month/Year | TO: Month/Year | TOTAL MONTHS: |
|---|---|---|

SUPERVISION:

This applicant received the following supervision from me:

INDIVIDUAL: _____Hours/Week GROUP: _____ Hours/Week

I hereby certify that at the time of the documented supervision, I met one of the following criteria:

❒ AAMFT Approved Supervisor ❒ AAMFT Supervisor in Training ❒ GA Board Approved Supervisor

DESCRIPTION OF PRACTICE SUPERVISED:

## OATH

I attest that the supervision described above is a true and accurate representation of this Practicum/Internship experience and supervision.

_____ _____
Date Signature of Internship/Practicum Supervisor

Subscribed to and sworn before me _____
this ____day of _____,_____ Printed Name

_____
Notary Public
My Commission Expires:_____ NOTARY SEAL

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# MARRIAGE AND FAMILY THERAPIST
# PRACTICUM/INTERNSHIP - MISSING OR DECEASED SUPERVISOR AFFIDAVIT
# FORM C

INSTRUCTIONS: Please type or print clearly. **NO FAXED FORMS ACCEPTED**

**APPLICANTS:**

- Make every effort to locate the supervisor(s)/instructor(s) of record as necessary to document the required Practicum/Internship Experience.
- You may show your diligence with returned mail, copies of letters, verifications from your academic institution, etc.
- If, however, after a diligent search you are unable to locate the supervisor(s), you may attest to undocumented supervision of practicum/internship by taking the Oath below.
- The Board may require additional information upon review.

## OATH

Under penalty of perjury as provided in the Official Code of Georgia Annotated, I hereby aver and swear that I was unsuccessful, after I made a diligent effort, to locate the supervisor below.

Name of Supervisor: _____

who served as my Practicum/Internship Supervisor in the practice of Marriage and Family Therapy

during the period of : _____ to _____
Month/Year Month/Year

and during that period he/she was licensed as a:

- ❒ Marriage and Family Therapist
- ❒ Professional Counselor
- ❒ Clinical Social Worker
- ❒ Psychologist
- ❒ Psychiatrist

License Number: _____ In the State of: _____

I have attached copies of letters and/or returned mail that demonstrate my attempt(s) to reach this supervisor.

_____ _____
Date Signature of Applicant

Sworn to and subscribed before me this _____
_____ day of _____, _____. Printed Name

_____
Notary Public
My Commission Expires: NOTARY SEAL

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# APPLICATION FOR ASSOCIATE MARRIAGE AND FAMILY THEREAPIST
## PERSONAL REFERENCE FORM
## FORM D

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- Please type or print legibly.
- Applicants must have references from **two (2) teachers or supervisors** who are familiar with their experience in Marriage and Family Therapy.
- **APPLICANT** - Complete Part I, give this form to your references with an envelope addressed to yourself. Retrieve the completed form from your reference for inclusion with your application.
- **REFERENCE** - Complete Part II, enclose this form in the envelope provided to you by the applicant, seal the envelope, sign your name across the envelope flap and return it to the applicant.
  The Board assumes that in recommending this applicant, references will interpret or substantiate to the Board your recommendation if the Board needs to contact you at a later date.

### PART I - APPLICANT

Name:

### PART II - REFERENCE

Name:

Address:_____
Street City State Zip Code

Day Phone: ( ) | Other Phone: ( )

Relationship to Applicant: ❒ Teacher ❒ Supervisor

Dates of Teaching/Supervisory Relationship: FROM: Month/Day/Year TO: Month/Day/Year

PROFESSIONAL POSITION WHEN TEACHING OR SUPERVISING APPLICANT:
Title:_____
Agency/Institution:_____
Address:_____

RECOMMENDATION: I ❒ Recommend ❒ Do Not Recommend the Applicant for licensure.

ADDITIONAL COMMENTS:
[Please write any comments that would assist the Board in making a decision on this Applicant for licensure.]

_____
Date Signature of Reference

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# POST-MASTER'S EXPERIENCE UNDER DIRECTION AND SUPERVISION CONTRACT AFFIDAVIT

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- The purpose of this Contract Affidavit is to define the employment relationship for the purpose of acquiring the required post-master's experience under the direction and supervision that will be applicable for licensure pursuant to O.C.G.A. § 43-10A et. seq.
- For the specific definitions of terms pertaining to specific licenses, see the Rules of the Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists (Chapter 135-5).
- In addition to the above, all contractual parties are required to adhere to all local, state and federal laws and regulations pertaining to all aspects of this contractual agreement whether written or implied. This includes, but is not limited to, the payment of local, state and federal taxes, minimum wage guidelines, assessment and collection of fees, insurance reimbursement claims, etc.
- Independent private practice or practice under O.C.G.A. § 43-10A-7, sections (9), (10), (13), (14), (15), (16) or (17) is **not** acceptable as "employment" for the purposes of obtaining directed experience under supervision.
- **NOTE: You must complete a separate Contract Affidavit for each directed experience site and /or supervisor.**
- **YOU MUST COMPLETE AND SUBMIT ALL 4 PAGES OF THIS FORM IN ITS ENTIRETY.**

## PART I — APPLICANT
* * * TO BE COMPLETED BY THE APPLICANT * * *

NAME: _____
Last First Other[Middle/Maiden]

ADDRESS: _____
Street City State Zip

HOME TELEPHONE: ( ) | OFFICE TELEPHONE: ( )

*SOCIAL SECURITY NUMBER: _____

*This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A. 1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

LICENSE APPLIED FOR: ❒ LAPC ❒ LPC ❒ LMSW ❒ LCSW ❒ LAMFT ❒LMFT

## EDUCATION

DEGREE EARNED: ❒ Master's ❒ Master's Specialist ❒ Doctorate: ❒ Ph.D. ❒ Ed.D.

ADDITIONAL COURSEWORK (Attach additional sheets, if necessary)

1._____
Course Title College/University

2._____
Course Title College/University

PRACTICUM/INTERNSHIP

Did you complete a Practicum/Internship as part of your degree program? ❒ Yes ❒ No
If "Yes," Name of Site: _____
Start Date: _____ End Date: _____
Name of Practicum/Internship Supervisor who was Instructor of Record for the course:_____
LICENSED AS: ❒ LPC ❒ LCSW ❒ LMFT ❒ Psychologist ❒Psychiatrist

At the time of your practicum was you supervision one of the following?

❒ AAMFT Approved Supervisor or Supervisor in Training ❒ GA Board Approved Supervisor

VERIFICATION

**I attest that I have read and understand O.C.G.A. Title 43, Chapter 10A, and Chapter 135 of the Board's Rules and I agree to comply completely with all laws of the State of Georgia and the Rules of the Composite Board governing the practice of any specialty licensed by the Board. Furthermore, I understand that I may not practice without appropriate direction and supervision until licensed by the Board, nor engage in independent private practice or practice under O.C.G.A. § 43-10A-7 (9), (10), (11), (14), (15), (16) or (17) while obtaining the required experience for licensure**.

_____ _____
Date Signature of Applicant

## PART II - DIRECTED EXPERIENCE
### * * * TO BE COMPLETED BY THE DIRECTOR * * *

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- The purpose of DIRECTION is to provide ongoing administrative oversight by an employer or superior in the practitioner's area of specialty.
- The Director is responsible for assuring the quality of the services provided and ensuring that qualified clinical supervision or intervention occurs in situations that require expertise beyond that of the employee.
- The Director must be located on-site and is specifically responsible for ensuring regularly-scheduled reviews of employee compliance with the Rules of the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists (Chapter 135) and all relevant federal, state, and local laws and regulations.
- **NOTE: Director and applicant (employee) must describe the content of the training experience and complete Part IV, Plan for Direction Section, on page 4.**

### DIRECTOR

NAME: _____

TITLE/POSITION:

IF APPLICABLE: ❒ LPC ❒ LCSW ❒ LMFT ❒ Psychologist ❒ Psychiatrist

Date License Issued: Expires: State: Highest Earned Degree:

HOME TELEPHONE: ( ) | OFFICE TELEPHONE: ( )

### EMPLOYMENT SITE

NAME OF EMPLOYMENT SITE:

ADDRESS:

Street City State Zip

OTHER PROFESSIONAL STAFF AT EMPLOYMENT SITE (ATTACH A SEPARATE SHEET, IF NECESSARY):

1. _____
   Name Degree License (If Applicable) Job Title
2. _____
   Name Degree License (If Applicable) Job Title
3. _____
   Name Degree License (If Applicable) Job Title
4. _____
   Name Degree License (If Applicable) Job Title
5. _____
   Name Degree License (If Applicable) Job Title

AFFIDAVIT AND SIGNATURES

**I attest that I have read and understand O.C.G.A. Title 43, Chapter 10A and the Rules of the Board and I agree to comply completely with all laws of the State of Georgia and Rules of the Composite Board governing the practice of any specialty licensed by the Board. Furthermore, I understand that this individual may not practice without appropriate direction and supervision until licensed by the Board, nor engage in independent private practice, or practice under O.C.G.A. § 43-10A-7, Sections (9), (10), (11), (13), (14), ( 15), (16), or (17) while obtaining the required experience for licensure.**

**I do hereby affirm under penalty of perjury that all statements made and information contained above are true and correct to the best of my knowledge and belief. Further, I hereby authorize the release of any information relating to information contained in this form that may be necessary to verify the accuracy of the information contained herein.**

_____

Signature of Applicant (Employee) Printed Name Date

Signature of Director Printed Name Date

Subscribed and sworn before me this _____
day of _____, _____.

_____
My Commission Expires:_____ **NOTARY SEAL**

## PART III — SUPERVISION
## * * * TO BE COMPLETED BY THE SUPERVISOR * * *

INSTRUCTIONS: **NO FAXED FORMS ACCEPTED**

- "SUPERVISION" is the direct clinical review, for the purposes of training or teaching, by a supervisor of interaction with a client/s in order to promote the development of clinical skills. It may include, but is not limited to, the review of case presentations, audiotapes, videotapes, and direct observation.
- The supervisor assumes complete clinical responsibility for all clients.
- The supervisor **does not** have to be located on-site.
- IMPORTANT: The requirements to be eligible to serve as a supervisor differ for Professional Counseling, Social Work and Marriage and Family Therapy. The number of hours and type (individual and/or group) of supervision is also specific to each license. See Chapter 135-5, Rules of the Composite Board of Professional Counselors, Social Workers and Marriage and Therapists for the precise requirements.
- NOTE: SUPERVISOR and APPLICANT (Employee) must complete PART V, Plan for Supervision, on page 4.

### SUPERVISOR

NAME OF SUPERVISOR: _____

TITLE/POSITION: _____

IF APPLICABLE: ❒ LPC ❒ LCSW ❒ LMFT ❒ Psychologist ❒ Psychiatrist

Date License Issued: Expires: State: Highest Earned Degree:

HOME TELEPHONE: ( ) | OFFICE TELEPHONE: ( )

SUPERVISOR'S EMPLOYMENT SITE:

ADDRESS: _____

Street City State Zip

Do you have any current or prior relationship with the applicant/employee? ❒ No ❒ Yes If "Yes," please explain:

MFT SUPERVISORS ONLY:

1. Do you intend to supervise this applicant for licensure as a Marriage and Family Therapist or Associate Marriage and Family Therapist? ❒ Yes ❒ No
2. If "Yes," have you obtained one of the following required designations?
   ❒ Board Approved MFT Supervisor ❒AAMFT Approved Supervisor or Supervisor in Training
   Supervisor's Name: _____

☞ See Board Rule 135-5-.06 for specific information.

AFFIDAVIT AND SIGNATURES

**I attest that I have read and understand my responsibilities as a supervisor under O.C.G.A. § 43, Chapter 10A and the Rules of the Board and that I will assure complete compliance with all laws of the State of Georgia and the Rules of the Composite Board governing the practice of any specialty licensed by the Board. In addition, I assume full responsibility for all aspects of the clinical services provided by this individual. Furthermore, I have reviewed this Contract Affidavit and will ensure that this individual will not practice without appropriate direction, nor engage in independent private practice, or practice under O.C.G.A. §43-10A-7, Sections (9), (10), (11), (13), (14), (15), (16), or (17) while obtaining the required experience for licensure.**

**I do hereby affirm under penalty of perjury that all statements made and information contained above are true and correct to the best of my knowledge and belief. Further, I hereby authorize the release of any information relating to information contained in this form that may be necessary to verify the accuracy of the information contained herein.**

_____

Signature of Applicant (Employee) Printed Name Date

_____

Signature of Supervisor Printed Name Date

Subscribed and sworn before me this _____
day of _____, _____.

_____

My Commission Expires: _____ **NOTARY SEAL**

## PART IV — TRAINING EXPERIENCE AND PLAN FOR DIRECTION

### INSTRUCTIONS:

- To be completed by the director and applicant (employee). Use additional sheets, if necessary.
- Describe in detail below the content of the training experience and the specific plan for "Direction."
- The plan must include, but is not limited to: 1) A description of the nature of the services being provided to the public; 2) the wages, salaries or other monetary considerations; and 3) a description of and declaration that both the direction and supervision occur on a regular basis.

PLAN FOR DIRECTION:

Signature of Director | Date | Signature of Applicant (Employee)

## PART V — PLAN FOR SUPERVISION

INSTRUCTIONS:

- To be completed by the director and applicant (employee). Use additional sheets, if necessary.
- Describe the specific "Supervision Plan" for this applicant (supervisee).
- "Supervision" means the direct, i.e., face-to-face, clinical review for the purpose of training, teaching, and promoting the development of clinical skill by a supervisor of a supervisee's interaction with a client/s. Supervision may include, but is not limited to, the review of case presentations, audiotapes, videotapes, and direct observations.
- **CONTRACT/AFFIDAVIT MUST SPECIFY THE NUMBER OF HOURS PER WEEK TO MEET THE 30 MINIMUM HOURS PER YEAR.**

PLAN FOR SUPERVISION

Signature of Supervisor | Date | Signature of Applicant (Employee)

| DATE APPROVED BY BOARD: | STANDARDS COMMITTEE: ❒ PC ❒ SW ❒ MFT |
|---|---|

| Standards Committee Member | Standards Committee Member | Standards Committee Member |
|---|---|---|

**OFFICE OF SECRETARY OF STATE**
**PROFESSIONAL LICENSING BOARDS DIVISION**
**GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS, SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS**
**237 Coliseum Drive**
**Macon, Georgia 31217**
**(478) 207-2440**

# CONSENT FORM

I authorize the **Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists** to conduct a background investigation of me to determine my suitability for licensure. I give my consent for full and complete disclosure of all records and information concerning myself to the Board, their authorized representatives, or any other persons deemed necessary by the Board in determining my suitability, whether such records and information are of a public, private, or confidential nature, to include criminal history records. This authorization will remain in effect for the duration of my active licensure status with this state or until cancelled by me in writing.

_____

Applicant's Full Name (Printed)

_____

_____

Physical Address (P.O. Boxes **NOT** Accepted)

_____ _____ _____ _____

Sex Race Date of Birth Social Security Number

Place of Birth (City/State): _____

Aliases or Maiden Name: _____

_____ _____

(Signature of Applicant) (Date)